Improving the health of our communities is a community-wide effort and begins with assessing community health status every three years. We obtain input from community members and public health representatives, consult with our hospital staff and physician partners to prioritize the community health needs identified, and develop specific targets and measures for the needs we are best positioned to address. Our implementation strategies are organized into three main priorities in alignment with three core principles of community benefit as shown in this progress report.

Priority #1

*Increase access for persons in our community with disproportionate unmet health needs.*

Focus | Access is an Aurora Health Care signature community benefit focus

Along with having a consistent primary care provider and medical home, access to medical care can detect and treat disease at an earlier stage, improve overall health, prevent disease and disability and reduce preventable deaths.

In 2017, 60 appointments were scheduled in our Emergency Department (ED) through the Milwaukee Healthcare Partnership ED Care Coordination program. 59 of those appointments were referrals to a Federally Qualified Health Center, with a 28% show rate.

Additionally, in 2017:

- 17 individuals received tele-intake services in our ED for behavioral health issues.
- 2,534 behavioral health assessments were conducted in our ED for people in acute mental health or substance-use issues to expedite referrals.
- 244 prescriptions were provided free of cost through our Essential Medical Fund to uninsured patients who had no resources for medications upon discharge.

Our hospital hosts a free drop-in blood pressure clinic twice per month to help community members manage their BP. (see page 2)
Focus | Behavioral and mental health and alcohol/drug dependence

Based on the key informant interview, mental health, alcohol and drug use emerged as one of our top five health issues for Milwaukee County. The residents of our South Shore communities ranked both mental health and alcohol/drug use within their top three health priorities.

Our Intensive Outpatient Program is specifically designed to help individuals through times of extreme fear, severe depression and anxiety, and teaches powerful, practical ways to respond effectively to any type of life-disrupting experience or major crisis, such as the loss of a loved one, job, health or relationship.

Our Partial Hospitalization Program provides intensive treatment five days per week from 9 am to 3:30 pm and is built upon the belief that recovery from mental health problems, including depression, bipolar disorder, anxiety, thought disorders, as well as co-occurring disorders can be achieved by addressing one’s psychological and social needs. Treatment includes psychiatric evaluation and medication management, individual and family therapy provided by any combination of psychiatrists, therapists, clinical nurses and case managers who develop customized treatment plans.

Additionally, in 2017:
• 2,530 behavioral health intake assessments were completed in our ED.
• We averaged 16.5 inpatient behavioral health services daily in our ED, a 5.2 partial hospitalization daily census for mental health, and a 4.8 intensive outpatient daily census.
• 7 support groups utilized our new Behavioral Health Community Resource Room.

Focus | Healthy blood pressure and healthy weight

To help community members track and appropriately manage their blood pressure (BP), we continued to offer free drop-in BP screenings and education on our campus twice per month. Following the screenings, our nurses provided one-on-one counseling and appropriate referrals to participants. To support community members managing their blood pressure in 2017:
• 20 free drop-in BP checks served 81 people, 7 of whom were unduplicated. Of those screened:
  - 28 individuals had a primary care provider
  - 20 were already being treated for high BP
  - 8 had high BP at the time of the screening
  - 2 had a first-time high BP
  - 8 were overweight/obese.
  - Following their screenings: 6 participants reported that they would call a provider, 12 planned to recheck their BP in one week, 4 reported intent to change habits, 2 lost weight, and 12 were referred for follow-up care and management.
• 1 off-site outreach BP screening was provided with 14 individuals screened
  - 11 participants had a primary care provider, 1 was currently being treated for high BP, 1 was currently prescribed BP medication and took the medication that day, 2 had a high BP, 2 were referred to a provider
  - Following their screenings, 3 reported intent to change habits.
Most cancers’ incidence and mortality rates in Milwaukee County exceed Healthy People 2020, as well as national and state rates. Many cancer survivorship care plans incorporate complementary and integrative medicine (CIM), such as mind-body interventions, support groups, financial counseling, enhanced general nutrition, nutritional supplements and physical activity. A growing number of studies suggest that CIM approaches may have a positive effect on survival of cancer patients.

During 2017, 102 new patients were served through our Cancer Nurse Navigator program. These individuals were supported as follows:
- 27 received nutrition counseling
- 9 received therapy
- 42 were referred to Aurora Family Service for counseling services
- 26 were referred to a social worker
- 10 were referred to a financial counselor
- 2 received integrative medicine
- 35 were referred to the American Cancer Society
- 7 were referred to Interfaith Older Adult Programs
- 1 was referred to the Aging Resource Center of Milwaukee County
- 3 participated in the Look Good Feel Better program

Our South Shore communities have a higher-than-average aging population. Milwaukee County’s median age is 34.0 years, while South Shore residents have higher median ages at 40.6 years for Cudahy, 37.0 years for Oak Creek, 45.0 years for St. Francis and 40.5 years for South Milwaukee. Of adults aged 65 years or older, one-third experience a fall each year. To address this in 2017:
- 100% of our ED patients aged 65 years and older were identified for screening with the Identification of Seniors at Risk (ISAR) tool, 68% were screened and 100% of those who scored a 4 were referred to social services.
- 1 Stepping On falls-prevention program was conducted with 21 participants. Stepping on promotes safe physical movement techniques for elderly patients at home.

Every gift can change a life.

Aurora Partnership Campaign

During 2017, a total of 203 hospital caregivers pledged $31,241 to the Aurora Partnership Campaign, their show of support to the not-for-profit agencies, organizations, and causes in our community that are most important to them. The campaign offers more than 1,600 funds that include more than 300 Aurora funds, local United Way agencies, and other not-for-profit organizations responding to important community needs.

To learn how you can make a gift to support programs featured in this report, please visit aurora.org/foundation

Aurora Health Care®

To see our most recent Community Health Needs Assessment report and Implementation Strategy plan, please visit www.aurora.org/commbenefits.